HHS/CDC Global AIDS Program (GAP) in Kenya – FY2003

About the Country of Kenya

Capital City: Nairobi
Area: 583,000 sq km (225,097 sq mi)
Population: 31.3 million

The HIV/AIDS Situation in Kenya

HIV Infected: 1.4 million[1]
AIDS Deaths: 140,000 adults in 2003[1]
AIDS Orphans: 890,000[2]

Kenya has a severe, generalized HIV epidemic with approximately 1.25 million adults and over 100,000 children infected. The Kenya Demographic and Health Survey (KDHS) 2003 found a prevalence of 9% in adult women and 5% in adult men[3]. Surveillance of HIV in pregnant women has been conducted annually since 1990, with prevalence rising to 16% in urban areas and 8% in rural areas in the late 90's but now showing signs of decline in some regions. Only 14% of Kenyan adults know their HIV status, limiting access to care.

About the Global AIDS Program in Kenya

Year Established: 2000
FY 2004 Budget: $9.9 million USD
In-country Staffing: 3 CDC Direct Hires; 43 Locally-Employed Staff; 7 Contractors[4]

Program Activities and Accomplishments

In FY03, GAP Kenya achieved the following accomplishments in the highlighted areas:

HIV Prevention

- Partnered with the Ministry of Health (MOH) to develop policy, testing, and counseling guidelines and training standards for the national voluntary counseling and testing (VCT) program. This resulted in expansion from three sites in the year 2000 to 220 sites, including 59 directly supported by CDC, that have served over 100,000 clients.
- Pioneered mobile VCT programs for hard-to-reach populations, introduced parallel finger prick testing (2001) and oral rapid tests (2003), and developed special youth-focused programs.
- Funded VCT promotion campaigns for youth and couples conducted with Population Services International that significantly increased the number of people requesting VCT services.
- Initiated a demonstration youth project in Asembo Bay on Lake Victoria, involving district officers, chiefs, parents, teachers, church, and community leaders in identifying the factors that contribute to HIV risk and in developing strategies to help young people avoid HIV infection.
- Supported the National Blood Transfusion Service and Kenya Red Cross Society to increase the number and percentage (now 60%) of low-risk, volunteer blood donors.
- Supported the International Rescue Committee (IRC) in providing HIV prevention and care services in the Kakuma refugee camp in northeastern Kenya.

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[1] Ministry of Health, CDC and UNAIDS, published in UNAIDS Report July 2004.
[2] 2001 estimate CIA World FactBook.
[3] Central Bureau of Statistics, Kenya Demographic and Health Survey 2003: preliminary report. ORC Macro.
[4] Figure represents a May 2004 census taken by GAP staff; staffing subject to change.

Preventing Mother-to-Child HIV Transmission (PMTCT)

- Provided financial and technical support for the development of a 5-year National PMTCT strategy that provides the guidelines and framework for coordinated program implementation.
- Supported PMTCT services in 118 facilities (including one offering PMTCT+), where 18,000 pregnant women learned their HIV status and approximately 40% of HIV-infected women received complete course of antiretroviral prophylaxis in a PMTCT setting.
- Worked with the National HIV/AIDS and STI Control Program (NASCOP) and the Division of Reproductive Health to integrate key PMTCT indicators into the Health Management Information System (HMIS) to ensure adequate tracking of program performance.

HIV/AIDS Care and Treatment

- Supported integrated tuberculosis (TB)/HIV services in the MOH and piloted these integrated services in slum communities, prisons, and urban settings.
- Piloted diagnostic testing and counseling (DTC) for TB suspects and patients and partnered with MOH to develop guidelines for HIV testing in clinical settings.
- Improved infrastructure and clinical services at government institutions to implement antiretroviral therapy (ART).
- Partnered with MOH, faith-based organizations (FBOs), and others to implement an ART program in the largest slum area of Nairobi, Nyanza Province (with the highest prevalence), and other sites.
- Supported community-based activities including training of HIV support group members in home-based care, legal issues related to HIV, and implementation of safe water systems.

Strategic Information, Surveillance, and Infrastructure Development

- Funded the first national HIV prevalence survey as part of Kenya's DHS and introduced mobile VCT for participants and communities. This is the first DHS to link behavioral information with HIV status, providing a wealth of information to guide and target program planning and development.
- Supported the first national behavioral surveillance survey in seven risk groups. More than 22,000 people were interviewed and 327 officers trained for the national program.
- Trained over 500 surveillance officers at 44 sites and introduced laboratory validation procedures and the use of dried blood spots.
- Supported the training of nearly 7,000 health care workers and other cadres; 997 health service providers have been trained in PMTCT, increasing coverage to five new districts. 3,745 health workers were trained in the delivery of TB/HIV services.

Challenges

- Maximizing the potential benefit of new resources provided by The President's Emergency Plan for AIDS Relief, the Initiative for Mother and Child HIV Prevention, and the Global Fund for AIDS, Tuberculosis and Malaria is a technical, programmatic, and administrative challenge.
- Implementing the PMTCT program within a collapsing public health infrastructure, poses a major challenge to expansion. Success will require flexibility in the use of resources.
- The six-fold increase in the national TB burden over the last 10 years, driven primarily by HIV and poverty, has exerted significant pressure on the available limited resources.
- HIV stigma discouraged TB patients from accessing HIV testing services.
- The national system for distribution of HIV test kits has not been able to cope with the demand for testing, resulting in disruptions in test kit supplies.
- Expanding HIV care and ART to rural areas will require improved physical infrastructure at health facilities, improved logistic management to ensure a continuous supply of drugs, and especially, increased manpower with the training, clinical competence and dedication to provide quality services for the whole population.